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Impact on Professional Relationships of the Presence of an Itinerant Night Nurse: A Qualitative Study of Care Homes for Older People

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Abstract

Background: A trial scheme to improving night-time nursing in residential care homes for dependent older people in the Ile de France region of France involved appointing degree-qualified nursing staff to circulate between three or four care homes. In most old age care homes, the absence of a qualified nurse to carry out health procedures during the night leads to night-duty care teams having to deal with urgent medical complications. This study aims to identify the factors which may impede the building of cooperative relationships between night staff and mobile nurses working in a number of medical settings.

Design: An inductive approach was used, based on analysis of in-depth interviews, observations and informal conversations to elicit the key themes. The field study was carried out over a four-month period from February to May 2015 in a number of selected residential care homes.

Methods: 35 semi-structured interviews were conducted with health professionals representing a range of paramedical categories, and 7 night-time participant observation sessions, in which the researcher accompanied mobile nurses during their night-duty work. 22 care homes were visited in total. The participant observation sessions included informal conversations to complete the data collection process.

Results: The findings demonstrate the importance of shared understandings of the organization of work among health professionals of different categories. Representations concerning mobile nurses by health care teams and their managers may have counter-productive effects and give rise to status tensions in relationships between care home staff. For their part, nurses who are not permanently present within care establishments have to employ strategies to maintain the cohesion with colleagues that their professional actions require, especially for managing emergency situations.

Keywords: Mobile night nurses; Care homes for older people; Interprofessional relationship; Nursing; Experimentation; Qualitative study; Geriatrics

Introduction

What is already known about the topic?

Previous research has explored the working conditions in night duty for nurses and nursing assistants in hospitals. These studies have highlighted the importance of the organization of work and the key role of managers in creating the conditions for an environment that encourages teamwork. They have also emphasized the importance of liaison between daytime and night-time teams. In addition, research has focused on the problems for health professionals caused by poor working conditions. “Stress of conscience” and “burn-out” are among the main consequences of interpersonal conflicts and inappropriate work loads. Lack of inter-professional communication, and inequalities in the distribution of decision making power, have also been identified as organizational risk factors.

What this paper adds

-This study shows the importance of relations of cooperation and of inter-professional trust for the work of site-based night duty teams and itinerant nurses working at a number of sites.

-The study also highlights the strongly determining effect of the organization of work in care homes, and of the positions adopted by nursing coordinators and senior health

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professionals, which influence the relations between night-duty teams and mobile nurses.

-The findings also show the importance of professional recognition in night-time work, which is still largely under-valued by the organizations in which it takes place.

In many residential care homes, night-duty teams composed of only two professional health workers share a work load that includes distributing medication and regular changing and washing, as well as management of incidents of nocturnal wandering and anxiety [1]. Night duty shifts can include times when there is a very high volume of activity for care workers [2]. Crises such as oxygen starvation, falls or severe pain, which may be potentially life-threatening for residents, are events which can create severe difficulties for small night-duty teams. Despite their experience and their acquired knowledge and skills, these health workers admit that their work generates a level of professional stress which is difficult to manage [3] and point to a major lack of training [4]. These night-duty teams are generally made up of pairs of nursing assistants, medico-psychological assistants or junior hospital care staff. In some homes all the tasks that go with night duty have to be performed by only two non-graduate health staff.

These health professionals are committed to putting the residents at the centre of their activities, an objective underpinned by the notion of quality of life. The care workers' mission is to optimise the care and the well-being of each resident, based on their individual needs [5]. At the same time, the current economic and regulatory context is centred on the output of these care institutions, which influences their way of working [6]. In this context, the main focus of management is on the productivity of the organization [7]. Minutely controlled allocation of supplies and equipment and a growing standardization of care procedures are two well-attested aspects of the organisational evolution of residential care homes. These different pressures induce managers to try to harmonizse interests which are a priori contradictory, aiming simultaneously to reduce costs and to raise the quality of service and of care [8].

To meet these aims and to respond to difficulties in handling emergency situations in medical and social care establishments for older people, the Agence Régionale de Santé (the organization responsible for health services at regional level in France) decided in 2013 to run a trial scheme to deploy state-registered graduate nurses in care homes in the Ile-de-France region. Twenty two nursing homes out of 709 in the region participated in this initiative. To make the scheme affordable, these staff resources were shared, with each nurse being responsible for 3 or 4 care homes which he or she had to visit each night. Part of the 22 nursing homes are participating since January 2013 and a second part in May 2013. In some cases official cars were made available for nurses to use. A nurse would have to travel 30 to 70 kilometers between care homes, with numbers of residents per home varying between 50 and 240, and exhibiting a wide range of degrees of dependency. Because of these pressures, and because some patient conditions entail severe loss of independence, nurses are obliged to work towards standardizing their interventions. For public authorities, reduction in night-time emergency hospital admissions and ensuring better management of emergency cases overnight were sufficient justifications for these experimental arrangements. Nurses were either recruited and employed by one of the institutions participating in the trial and using their services, or by an external agency specialising in the care of older people (a geriatric hospital or a home nursing care service). Nurses were trained (for employment adaptation) several weeks in order to carry out their mission. This training consisted of: a one week internship in a hospital emergency department, a week in an acute geriatric hospital unit and 3 weeks in nursing homes during the day. The staff was recruited in late 2012, they have been trained a week of theory on situations that the nurses may encounter. Twenty-one good practice sheets specifically dedicated to their mission were created and validated by an expert group, and they were trained to intervene in accordance with those protocols.

When they are on duty, the itinerant or mobile nurses start by collecting handover information passed on by their colleagues working during the daytime, who are supposed to fax them the information they need relating to their activities. In some cases, mobile nurses complete this handover information by means of phone calls to the night duty teams in the care homes they have to cover. Once they have this information, night nurses plan their visits to the different homes according to the priorities which have been identified through this information. Some prefer to structure their interventions to take account of the distances between the homes, or to fit in with the organization of each night-duty team. When they arrive at a home, some go straight to the nursing station, and others go around the corridors to find the staff on duty.

This research is one of the first qualitative studies to take an interest in night work in care homes for elderly. Previous research has examined the working conditions of night nurses [9,10], particularly in hospital settings. In the present case, the sharing of night nurses across different sites, and the mobility this requires, shapes their work in a specific way. They are responsible for some hundreds of residents in total, and have to find a way to cooperate with different night-duty teams. In this context, the questions which we have to ask are: how do these mobile state-registered nurses working for short periods in each home and staff who work at night for some years in a particular home accommodate themselves to each other? And to what degree is this experimental form of organization, which has been conceived and orchestrated by nurses and doctors outside the care homes, accepted inside them?

Aim

The aim of this field study was to follow mobile nurses in their night-time interventions so as to identify the forces driving or preventing their incorporation into the different institutions involved in the trial.

Methodology

Design

The study was qualitative and descriptive in design. Interviews with health professionals in daytime and night-time teams, and participant observations, were conducted in the setting of the participating institutions. The qualitative study took place 2 years after the beginning of the trial scheme in February 2013. The field investigation took place between February and May 2015 and was carried out by a researcher from INSERM (Institut National de la Santé et de la Recherche Médicale – National Institute of Health and Medical Research) who has a Masters degree in sociology and anthropology. Initially the researcher met health professionals working during the daytime in 7 care homes pre-selected by the regional health authority (1 private for profit, 3 private not for profit, 2 public and 1 associative). The setting up of the experimental scheme lead to staff meetings that include or not include persons of all professional categories, depending of the case. Managers informed care teams about the new presence of a night nurse. The effectiveness of these meetings have varied depending on the institution. 5 of the homes visited in the daytime had received government funding to recruit night-time mobile nurses. These initial meetings were an opportunity for the researcher to prepare the ground for the research by presenting the approach to the health professionals, and to invite them to discuss their perceptions and feelings about the new arrangements and about their experience of them.

Interview guide

The interview guide covered four thematic areas identified in the first interviews with health professionals: first reactions to the announcement of the setting up of night nursing arrangements; the key events experienced by care workers in relation to emergency situations; the experience of inter-professional collaboration; and the constraints and drivers identified as well as the strategies deployed by the different professionals. During the interviews, the researcher adapted the interview to the discourse of the interviewees, prompting discussion of the themes in the interview guide: “It is a matter of stimulating discussion, after agreement in principle with the person being interviewed, and facilitating it in order to explore the information the interviewee has to offer about the subject - what he or she has to say about it” [11]. Interviews lasted between 30 and 60 minutes, and were recorded and transcribed in their entirety.

Places and participants

All the data collected have been anonymized. Names of places and people have been changed.

One residential care home in each Département of the Ile de France region (not including Paris) was investigated by the researcher in the daytime. He was received by health and nursing managers and met the teams in place, which were composed of nurses, nursing assistants, medico-psychological assistants and junior hospital workers. Semi-structured in-depth interviews were held one-to-one with individuals in each professional category who agreed to take part in the research. An information letter explaining the study was sent to the management of each home selected in advance to be part of the research. For the night-time investigation, the researcher accompanied and interviewed the mobile state-registered nurses who agreed to him being present during their night-time interventions. While accompanying them the researcher was able to meet those working in the care homes at night and to carry out semi-structured interviews with them in the 7 selected homes.

Observation and informal sources of data

The researcher accompanied 7 mobile nurses during an entire night shift. He shared their working environment and assisted them where necessary (by helping to carry equipment etc.). This position allowed him to consider the whole range of activities carried out by these health professionals in the course of their work [12]. These data were recorded in a field notebook.

Analysis

The data consisted of numerous descriptions of situations and of testimonies by the health professionals. These two types of data were analysed comprehensively, taking account of the context in which they were generated [13]. Analysis involved of examining dispassionately the linguistic usages and the individual and collective lived experiences of the experimental scheme, as well as its impact on the organization and quality of care. Gaps between representations and practices were analysed. Combining the emic (actor’s point of view) and the etic (observer’s point of view) enables an analysis to be made of the symbolic structures at work and the practices [14]. Anthropology, going beyond the particular cases described by means of detailed ethnography and case study, aims to detect recurrent patterns. On reading the first interviews, the researcher identified specific emergent themes and recurrences. For each interview a summary portrait was produced, which synthesizes the unique experience of each interviewee. Informal data (interviews, observations of spaces and interactions) are used to contextualize and analyse the verbatim accounts and to sharpen their relevance through a triangulation of data and sources of information. This mass of empirical data finally reaches a saturation point, after which later observations and interviews do not add new meaning to the phenomena observed. The material collected (the interview transcripts) and produced (summary portraits and field notes) were treated using Nvivo 10 software. The results of the study were also discussed by a multidisciplinary team composed of a geriatrician, and epidemiologist and an anthropologist.

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Ethical approval

The Institutional Review Board (IRB0000388) of INSERM (IORG0003254, FWA00005831) gave approval for this research.

Results

Setting up the mobile night nurses trial scheme

The launch of the mobile night nurse trial raised a number of issues for care teams. For the night-time duty teams, this new arrangement provoked questioning concerning access to nursing expertise, but also concerning the role the mobile nurses were to play. According to one of them, a lack of clarity in the organization of work caused misunderstandings when the arrangement was announced and set up:

There wasn't really any special arrangement, there was no real organization with a complete set of procedures, so how to make it work….? It was us in the end, we had to try to see what the care home team expected, but there was no job specification as such to set out in detail "what I have to do, and so on and so on". That was true for us, the night nurses, but for the assistants too. The nursing assistants were a bit lost as well, because they also didn't really know how to do things now. Now there is a night nurse, when are they supposed to call us, when….. ? Anyway, it was all a bit vague for everyone, you know, at the beginning. (Amnastana, mobile nurse, aged 43)

The mobile nurses' roles were not clearly defined from the start, which created organizational difficulties for the nurses themselves and led to expectations on the part of the night-duty teams which were sometimes unfounded. In some care homes, the team thought they were getting back-up support which would relieve them of some of their scheduled tasks. One nursing assistant spoke about her questions concerning the presence of the nurse, and described her expectations concerning the difficulties she had:

In terms of knowing if it was going to make our work easier than before […] Are they going to help us to turn the patients or to change them [hygiene and comfort care also known as nursing care]? Are they going to help us to give medication? Because there are some medications that have to be given at night. Sometimes you find yourself with a nursing assistant, because some nursing assistants are allowed to give medication. Sometimes it happens that I am the only nursing assistant in the evening and I have to give the medications in the other units, to visit other units, to go into another wing and give out medications, and when it's like that, the bell is going all the time. They want their medication before going to sleep, so having nurses here, for us, it was for that kind of thing. (Queen, night nursing assistant, aged 50).

The night-duty teams also drew attention to the difficult working conditions at night, whenthe heavy workload sometimes overloads the staff available. They are aware that they regularly go beyond their official levels of competence in responding to situations which may be of vital emergency for the residents they are looking after. The night-time nursing assistants who were interviewed spoke about these kinds of actions which go outside their official sphere of professional competence:

When there are sores, when there was a small sore, we used to deal with it by ourselves (Denise, night nursing assistant, aged 56).

When there was a fall, we used to treat it ourselves, we would disinfect, put on adhesive plasters or... afterwards, we would keep an eye on the person's condition all night (Marion, night nursing assistant, aged 39).

The nursing assistants, aware of the fact that some of their actions were not legal and exposed them to possible sanctions, interpreted the provision of nurses as the result of suspicion towards them by their superiors. The presence of a nurse was hard to accept and was a source of misunderstanding. The provision of a qualified nurse might be perceived as devaluing their habitual work, so the nurse was sometimes faced with a passive or even resistant attitude from the night-duty team. One nursing assistant explained the feeling of incomprehension she experienced when the trial was launched:

We used to be super-independent, so yes, it's true that we didn't really understand when the nurses arrived […] In the beginning it was complicated to adapt because we had always been left to ourselves […], and we questioned ourselves a lot, we said "yes, it's strange, now we are chaperoned" so to speak, whereas for years we have always managed on our own, we always coped with emergencies without too much being done wrong, we even always used to manage deaths (Christiane, night nursing assistant, aged 42).

In the same vein, Amnastana, one of the mobile nurses, recalled how her activities began, the difficulty she had in getting information, and the kind of things the night duty teams used to say:

They took it rather badly at the beginning because they said: "OK, so they don't trust us any more, although it was us who did all these jobs before, now suddenly they have to send a nurse because they think we are not capable of managing it all". So there were some who wouldn't give me any information, it was very complicated in some homes […] they had plenty to say to each other in the treatment room but to me, nothing (Amnastana, mobile nurse, aged 43).

The success of the staffing arrangement, or the emergence of obstacles to it working properly, was influenced by the way in which these cooperative relations between professionals were established or not. In the discourse of the interviewees, the mobiity of the nurse and the relative statuses in the professional hierarchy were the main features which had an impact on working relationships.

Obstacles to successful intervention and nurse mobility

When they start their duty, the mobile nurses begin by collecting the nursing information handed over to them by the

night teams in the homes where they are to work. In some cases nurses complete these handover notes, sent to them by fax, by means of a phone call to the care home teams, who give them additional information. Once they have collected all this information, nurses work out their visits to the different homes according to the priorities they have identified, although some prefer to structure their interventions according to the distances and routes between homes, or the way each night duty team organises itself. When they arrive at a home, some nurses go straight to the nursing station while others take to the corridors to look for the duty staff.

The fact that the nurses are mobile sometimes makes it difficult for them to be integrated into teams who are used to working on their own. The workload assigned to them may vary from one site to another, which also makes it difficult for them to standardise their interventions. Sometimes particular problems or difficult situations faced by a team may make the nurses arrive behind schedule, or they may arrive unexpectedly, and this can also give rise to reactions which become an obstacle to inter-professional cooperation.

In some care homes, the daytime teams regularly programme non-urgent tasks which need to be attended to by the night nurse. This over-timetabling can conflict with equitable sharing of the nurses' interventions between the different sites. This is a phenomenon which is accentuated in Départements where the nurses are employed by a lead institution in which they also work. Some nurses end up doing more work in those places where there are instructions from the daytime team. The tasks assigned to them may include preparing pill dispensers for the next day, or routine care to be given during the night (such as changing bandages). One of the nurses interviewed explained her refusal to respond to all the demands made by care homes, which she considered to be preventing her from fulfilling her programme of visits:

The idea is that we are there to intervene as the need arises, visiting regularly but only intervening occasionally when there is a problem, and that shouldn't mean that every night I am doing a dextro [from the Dextrosix brand, referring to measuring blood glucose in diabetic patients], or that I come by to do a drip for this and that patient, but there it is, that kind of thing removes all the point of our being mobile nurses (Melanie, mobile nurse, aged 45).

This phenomenon of certain care homes monopolising nurses is the cause of a lot of delays. When nurses are called by a night-duty team having difficulties in another home and are not able to intervene in time, the night-duty teams deal with the situation on their own, as they used to do before the new staffing arrangements; and so the advantages of these are called into question by the care home teams:

They [the nurses] have three homes to cover, and most of the time, if there is really a problem, the person is not there. So anyway, we just carry on as before, we take things in hand ourselves. You see, waiting for them to come, we end up dealing with things ourselves, so that means that it's us who call the emergency number, and we give first aid […] They aren't there, we have to manage, so we go back to square one and there we are. It makes you wonder whether it is all worthwhile! (Denise, medico-psychological assistant, aged 56).

In addition, because they themselves cannot monitor night work, some managers have instructed the nurses to supervise the work of the night-duty teams. According to one manager, the status of the night nurses necessarily leads them to establish relations of supervision and control with the teams in the care homes. She justified her position in the following way:

Professionally speaking, we were able to have someone who was, shall I say, hierarchically placed in relation to the night-time nursing assistants […] and to monitor and supervise them, which can sometimes enable you to correct the inappropriate activities of night-time nursing assistants, because I am not there myself at night, and as they say "when the cat is away the mice will play" (Nadine, manager, aged 34).

Nurses' interventions in some care homes can sometimes run into tensions which are generated by the distrust the night-duty teams feel towards their hierarchical superiors' efforts to control them. A night-time nursing assistant describes these relations of subordination:

Here you don't have the right to rest, you aren't allowed to lie down at night, they don't want you to close your eyes. Sometimes they [the managers] come by to check about two or three a.m. to see if you are lying down. I have a colleague who got a warning for that. (Aude, night time nursing assistant, aged 28).

State-registered mobile nurses talked about the difficulties they have in establishing good relations with the care teams, and the defiant attitudes they encounter:

At the beginning the atmosphere was difficult, especially here. People thought it was a kind of policing. They thought we were the eyes and ears of the management. That was it… that we were going to report on everything that happened at night and all that kind of thing that we were there to spy on them. (Laure, mobile nurse, aged 56).

They thought we were coming to watch them, to take them by surprise, I don't know what…… Anyway, there it was, there was that kind of distrust at the start (Amnastana, mobile nurse, aged 45).

The study showed that in some Départements, the mobile nurses continued to have difficulties in cooperating with the night-duty teams, who were resisting their interventions. These kinds of behaviour generally involve a major lack of communication, which prevents the nurses from obtaining the information needed for their interventions. In these cases, the nurses feel frustrated:

By joking, I manage to get hold of the information. Sometimes the nursing assistant will say to me "Oh, no, it's ok, there's nothing much". They say that - "no, no, there's nothing much" when really there is plenty to tell. Sometimes it doesn't work […] the last time I wanted to explain Hepatitis C, the nursing assistant didn't even listen to me, so I let it go. (Sandra, mobile nurse, aged 50)

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In other contexts which are more favourable to nurses' interventions, cooperative relationships have been built between night-duty teams and mobile nurses. The nurses have made efforts to build relationships of trust with the night-duty teams, taking stances which encourage cooperation.

Valorization of night duty teams and good inter-professional communication

The nurses' mobility makes them completely dependent on the night-duty teams. Because they cannot always intervene in a timely way in emergency situations, they have to delegate to the teams on the spot by phone. The nurses, who are are responsible for more technical forms of care (which are more highly socially valued), and who hold significant symbolic capital, are able to encourage or discourage the night teams and to choose whether or not to delegate to them some actions which are more technically advanced or carry a higher responsibility, enabling nursing assistants to valorize their work. One mobile nurse recounted a situation where she had supported a nursing assistant by phone to enable her to deal as effectively as possible with the difficulties she was facing:

I was already busy looking after a patient elsewhere and I was much too far away, so in the time before I could get there we would have lost too much time, so we talked on the phone and I gave guidance to the nursing assistant, and everything went fine between us, and the person could act fast because she knew the information to give to 15 [phone number of the medical emergency service] […] anyway I said "ok listen, colleague, I can't get there right away, so take the vital signs, keep and eye on the consciousness, check the pain level and see if there is a fracture somewhere, and call 15 because I can't be there, if I can get away I will come as quickly as possible but if I don't make it, do what you have to do" (Ines, mobile nurse, aged 30).

Some nurses, aware that the effectiveness of their presence cannot be separated from the activities of the night-time teams, insist on the importance of trusting the nursing assistants they work with:

Above all I had to build a relationship of trust with the girls and be able to explain to them that I was really there to work with them, that we were a team, even though it's true that I am not part of the same establishment and I don't wear the same uniform as them, but I was there to work with them because they needed us and we needed them […] and in the end if we can't work with the nursing assistants I think it will be a major handicap because they are our eyes and our hands when we aren't there, and our work depends on them too, so it's important to be able to work properly and have good relationships with them so that care is done correctly and in a good spirit (Ines, mobile nurse, aged 30)

Nurses are sometimes obliged to adjust the practices of the night-duty teams when they see that there are inconsistencies in care. These teams are not used to having nurses with them during their various activities, and they have sometimes developed bad habits. Regular re-evaluation of practice is an important dimension of the work of the nurses who want to "make things better":

[Concerning the protocols which have been established and in which they have been trained] We said to the girls "if you need to go back over such and such a procedure, don't hesitate to ask, we will go over it again", because you come across situations where you have been effective, or not, you have missed something and have not had such good results. What was missing? So you go back over it. (Pauline, mobile nurse, aged 41).

Seen in this way, the presence of the nurse is not felt by the night-duty teams to be a control over them in an oppressive sense. The nursing assistants in the study found that the presence of a nurse gave them authorization to take part in the nursing diagnosis, for example in an emergency situation. In such a case the health professionals involved showed that they were listening to each other, which encourages joint decision making and sharing of responsibilities. The care teams particularly appreciated being consulted when the state-registered nurses made a decision:

We are junior to her but afterwards she still asks us, she may say "how do you think she is? I don't know her very well" and in fact we guide her….., it's important that she refers to us because we know them [the residents]. (Christiane, night-duty nursing assistant, aged 42)

She [the mobile nurse] goes to see the patient, she sees the patient is asleep so she comes back later: "oh, but she's asleep, what shall I do and what do you think?" and so on. So we talk about it, and then she decides whether or not to put the drip back in. There are some patients, when they are asleep you can inject them and they don't feel anything, so we know that and we can advise, we can help them do their work so that it's right, so as not to disturb anyone because it's night time. At night you should be sleeping and not be disturbed in your sleep. (Sylvie, night-time nursing assistant, aged 45)

The mobile nurses intervene together with teams who sometimes have years of experience of night work. Some nurses felt it was important to valorize this. They explained their position on the work done by the teams and gave consideration to the specific capacities they have developed while working independently:

We need them, and for me it's a real team effort, anyway that's how I want it to be, and I think I can manage to make it happen like that, because the idea is not to replace them, okay we are here but we don't do all the work, we really need them to do their part of the work too, they were here long before us and they have always known how to do things, sometimes rightly and sometimes wrongly, but they have always responded. (Ines, mobile nurse, aged 30)

Generally we are working with care teams who are motivated, dynamic, involved, who want to learn and want to train themselves […] They know I am in the office, that I am completely available for them, but if there's nothing going on, if everything is calm, I leave them alone. That's the strategy I

have developed from the start so that they don't feel I am there to control their work. (Pauline, mobile nurse, aged 41)

Beyond this type of consideration for the night-time teams, some nurses take advantage of their status to bring difficulties that occur at night to the attention of their managers who work during the daytime. These problems are often linked to delays in providing care. Information is often passed on by the night-time teams who regularly flag up residents' problems, but these are not always taken into account by the daytime teams:

At least when she [the nurse] says something, she is listened to (Chantale, night-time nursing assistant, aged 53)

When the night teams know that the nurses intend to make changes in the care home practices, they regard them as "spokespersons" enabling the night staff to make themselves heard by their managers on questions of work organization.

Discussion

The impact of representations in building cooperation

For nursing interventions to be efficient, one of the necessary conditions is close collaboration and good communication with night-duty teams [15]. These teams have to carry out activities delegated to them by the mobile state-registered nurses at times when the nurses are not in the residential care homes. But in some cases the organization of work in the homes is an obstacle to building these cooperative relationships between health professionals, and creates particular difficulties between the daytime and the night-time teams [15,16]. Cooperative relations which enable good inter-professional communication are essential for better night-time care of residents who have specific needs and require urgent treatment [17-21]. But our research shows that the representations of nurses within some night-duty teams are negative, suggesting distrust by night staff of their line managers, and this is liable to undermine the building of the necessary cooperative teamworking relationships. Senior managers seeking to maintain control within their care homes subscribe to and transmit these kinds of representations, which assign a role of surveillance to the nurses. The question this observation raises is whether there is a direct link between these perceptions of nurses by managers and the reactions of resistance of the night-duty nursing assistants towards them. As proposed in a systematic review [22], it would be interesting to explore further the nature of the relationships which are built up between the night-duty teams and their managers.

Professional distance and valorization of night-duty teams

The mobility of the nurses means that they cannot carry out regular nursing care activities alongside the night-duty teams [23]. Delegation of tasks is therefore mainly from the top downwards. This kind of delegation towards nursing assistants could be seen by them as a source of empowerment [24]. Where inter-professional collaboration works well, it enables the independence of junior staff to be maintained through the transmission of knowledge [25]. But some management initiatives can sometimes create confusions and misunderstandings among nursing teams [24]. Effective cooperation depends on the individual strategies deployed to encourage team working [26]. Our study highlights the importance of how the night-duty teams feel, as a determining factor in the collaboration with nurses who have to delegate tasks to them and to alter some of their nursing care practices. For these relationships of authority with the nurses to be accepted by nursing teams, they need to be as unconstraining as possible. External constraints imposed by the interventions of nurses must not be imposed on night-duty teams or call their autonomy into question, because this is the source of their professional status. From this point of view, the value accorded to the knowledge and the autonomous practice skills of night-duty nursing assistants by mobile nurses becomes a form of compensation for the relations of power and domination imposed by the hierarchical management structure. This sort of compensation encourages the birth of relationships of trust, through which cooperation can be built. However, one may question how a nurse who has experienced a professional demotion on her arrival in France – for example, a female medical doctor from another country, working as a nurse – may situate herself in relation to night-duty teams who sometimes have more than ten years of experience in night-time care in residential care homes [27].

Interprofessional communication and the idea of trust

The mobile nurses are not in a position to know all the residents and to live in shared intimacy with them, unlike the night-duty teams who work at their bedsides every day [23]. This unfamiliarity with the residents, and the consequent inability to follow their care closely, may be at the root of some of the major stress experienced by health professionals [3]. In emergency situations, the spread of stress through a team may lead to significant problems [17,18]. Supervision by a nurse who intervenes both in the day and at night seems necessary for the continuity of care [28]. In the setting of our research, the organization of staffing does not allow for verbal exchanges between the mobile nurses and the daytime teams. Notes received from the daytime nurses are the main sources of information for the night-time mobile nurses preparing to intervene in care homes. Information may also be shared through oral communication with the night-duty teams in the different homes, who have been informed by the daytime teams about the care procedures and observations that are needed.

Our research shows that the quality of these moments of direct exchange with night-duty teams varies with the position the mobile nurse occupies in the hierarchical relationships within the care homes where she works. In addition to clear definition of the role of the nurses, the night-duty teams also need to know about the motivations of these nurses who are

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operating in their workplaces. Knowledge of motivations contributes to inter-professional circulation of information, which is founded on relationships of trust. But occasional help with nursing care itself depends on interpersonal relationships and cannot contribute to long-lasting relationships of trust. The notion of "teamwork" and collective care has an important role in the symbolic universe of the night-duty nursing assistants in our study; so a stance on the part of nurses which enages the collective interest can encourage durable inter-professional trust. This stance by the nurse mainly involves communicating the problematic situations facing the night-duty teams to the daytime teams, and it is also perceived as a support to achieving the quality objectives of the night-duty teams.

This aspect of the intervention of mobile nurses raises questions concerning the unequal power relationships within residential care homes, seen in practice in the way that the organization of care does not take into account what the night-duty teams have to say. Such a lack of consideration may have a negative impact not only on the quality of care [29] but also on the health of the nursing assistants, who feel that they are not performing well [3]. The way in which the problematic of night duty becomes invisible is a reflection of unequal power relationships between the professional categories [30,31]. In this context, the intermediary role of the mobile nurses may contribute towards improving working conditions for the night-duty teams, or may accentuate the existing divisions between different professional categories. It would also be interesting to analyse the impact of their presence on the relationships between daytime and night-time teams.

Strengths and Limitations

The paramedical professionals who took part in this study showed a strong interest in the research, which enabled the researcher to collect testimony that was rich in the experiences of each professional category involved in the trial. It would be interesting to carry out interviews with coordinating clinicians and managers, which would be a way of widening the analysis to include other professional groups.

Conclusion

New night-time nursing staff arrangements have faced difficulties which have varied with the organizational contexts in which they have been tested. The positioning strategies of some mobile nurses have enabled them to mitigate the status-related tensions they encountered in different care homes. Lack of precise definition of their role was a factor which was a barrier to their integration into care teams. Sometimes perceived as supervisors in the service of senior management, they faced mistrust from night-time teams who are regularly working beyond the limits of their official competence. Cooperative and trusting relationships between mobile nurses and night-duty nursing assistants, which are vital for managing emergency situations, have sometimes been hard to create. These trusting relationships are the main drivers of the successful introduction of mobile night nurses. Cooperative relations between actors allow all to have an equal voice, and enable a shared normative framework to be built up. For night-duty teams and mobile nurses to share common rules, there has to be a continuous process of debate and discussion: nurses have to go beyond controlling relationships in order to establish trust, letting go of the strictly hierarchical function which might be theirs in the daytime organization of duties.

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